The Scottish Birth Record

Coding User Manual

June 2011

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Section 1: Background & Introduction

Welcome to the Scottish Birth Record (SBR) Coding User Manual.

There are two separate yet dependent modules to the SBR system. There is the **clinical module**, which can be completed by midwifery, neonatal and paediatric staff as well as administrative staff where appropriate. This then feeds the relevant data items into the smaller **coding module.** The coding module is then amended and checked by trained coding staff. Amendments to clinical data items by coding staff do not change the entries made on the clinical side. The coding staff also add any diagnostic codes (ICD10) and procedural codes (OPCS4) where appropriate and submit the record to the national central database.

Until 1996 every baby was entered onto the SMR11 scheme. At that time it was decided that details of healthy babies should reside on SMR02 (maternity), and the SMR11 would be reserved for 'sick' babies and those with congenital anomalies. However, this did not prove successful and there was confusion over what constituted a 'sick' baby. There was also an unacceptably low level of reporting of congenital anomalies.

The SBR has replaced the SMR11 reporting scheme and every baby born in Scotland will have one (and only one) Scottish Birth Record. All 'sick' babies born from the 1st April 2003 are being entered onto the SBR system. In due course we aim to record all births in Scotland including homebirths and stillbirths. The SBR system provides the functionality to record **all** of a baby's neonatal care in Scotland, including readmissions and transfers in **one** record.

The growth of Internet technology has allowed us to devise a web-based reporting scheme. Although the SBR is a web-based system it does not reside on the public Internet, instead it is on the NHSNet, which is the NHS private version of the Internet. All interactions are password protected and the system now has a full audit trail.

We are planning further work to build on the SBR's ability to share data. This will bring additional benefits to areas such as: direct patient care; service management; planning, and research. Already the SBR extracts data from clinical maternity systems and Patient Administration Systems and can be used to interface with the system which generates Community Health Index (CHI) numbers (62% of babies in Scotland already get their CHI number this way). We plan to build further interfaces so that data can be more effectively shared amongst all relevant systems – maternity, neonatal and child health surveillance. The end result shall be a clinical and coding system which will play a pivotal role as a 'key node aggregator' in the future sharing of data.

Section 2: Log In

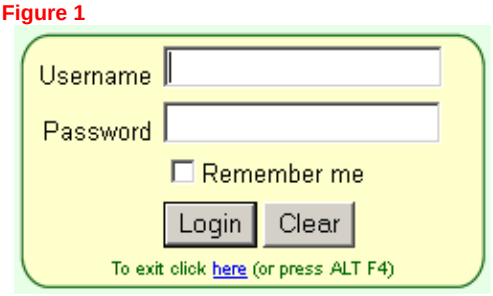
There are **two** Scottish Birth Record (SBR) systems in operation **– 'Live'** and **'Training'**. To access these systems:

- Double click on the relevant icon 

or 

- see Appendix B "Setting Up Icons on Your Desktop"
- Enter a username and password
- Click on Login button

Figure 1



NB. If you tick the 'remember me' box, the system will automatically remember the last username entered so that you will not have to enter it again when logging back in.

The Training System

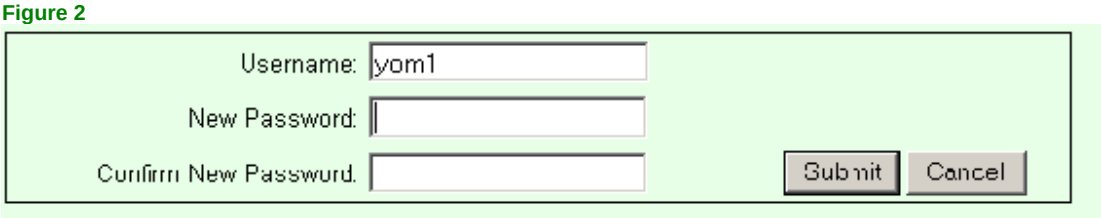
Please contact your local administrator or the SBR Team to confirm the username for your hospital. Your training system password is **'training 1'**.

PLEASE NOTE - The training system does not reside on a secure website therefore please **DO NOT** enter any **CONFIDENTIAL DATA.**

The Live System

To access the live SBR you will require a unique username. You can obtain this from your local SBR Administrator or the SBR Team - see Section 16 "Contacting Us".

Figure 2



For first time users, or if your password has been reset, the password is **'password'**. Once you have entered your login details you will be prompted to provide **your own secure personal password that must be at least 6 characters long with 1 number**.

PLEASE NOTE – you **must** only enter the system using your **own unique username** and **password**.

If you have any problems accessing the SBR, including forgetting your password, please contact your local SBR Administrator or the SBR Team via the ATOS helpdesk for advice.

Section 3: The Coding Dashboard

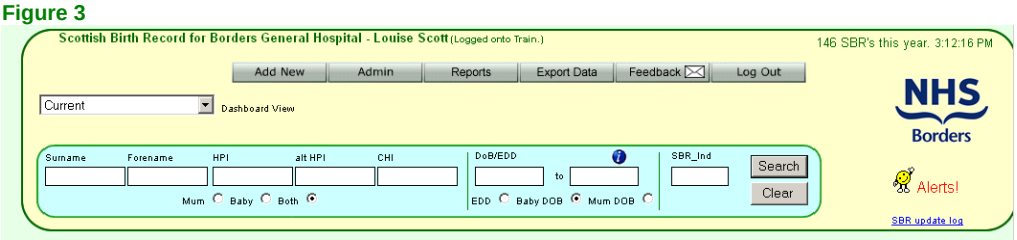
Once logged in you will be presented with the **dashboard**, a screen showing summary patient details that also gives you access to system administration and enhanced system functionality.

The top section identifies the user, site and relevant NHS Board. It also provides access to additional functions:

- Add new record
- Accessing alternative dashboard displays
- Searching for records
- System and password administration
- Reports
- Exporting Data
- Contact
- Logging out
- User alerts where records require attention
- SBR Update Log

These functions are described in detail later.

Figure 3



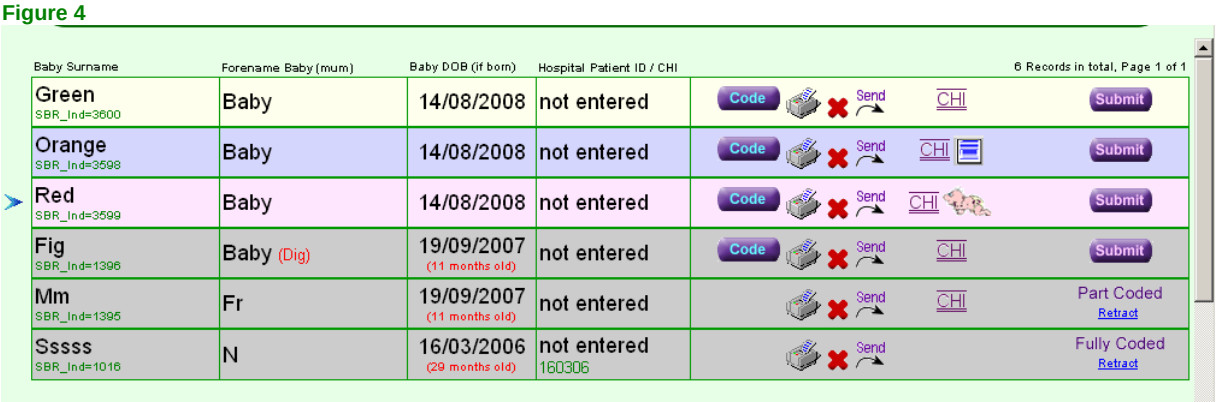
The lower section provides access to your patient records. It also:

- Provides access to the print room
- Provides ability to delete a record
- Provides ability to send a record to another location
- Provides access to the CHI interface (where implemented)
- Indicates the transfer/sent status of a record
- Provides access for submitting records to ISD
- Indicates the coding status of each record

If a record has a blue background, it is a boy, if it has a pink background it is a girl, and yellow backgrounds are when the sex of the baby is unknown. A grey background indicates a record over 7 months old.

A count of records together with the number of pages is provided for information. Again these are described in detail later.

Figure 4



Viewing Alternative Dashboard Displays
The option for dashboard displays are:

- **Current** - Records which have a baby's date of birth recorded but do not have a discharge entry, this excludes still births, home births and babies recorded as being 'born outwith scotland' unless they are subsequently admitted to your hospital. Note - All births pre 2004 are excluded from current views
- **All** - Every record which is stored within the system at your hospital
- **Booked (not yet delivered)** - Any mum which has been booked into the system but is still to deliver
- **Four weeks after EDD** - Any Mum which has gone 4 weeks (or more) past their EDD
- **CHIs to be allocated** – SBR records which do not have a baby CHI entered on them
- **Invalid CHIs** – SBR records which have an invalid baby CHI entered e.g. only 4 digits
- **Invalid baby dates of birth** – SBR records where the baby date of birth is entered at that time to make the baby over 10 years old, or an incorrect date of birth e.g. 40/07/07 or 21/13/06.
- **By ward** - Everyone recorded as currently being within the selected ward

When you first enter the system it defaults to display the current records. You can change to any of the views mentioned above by clicking on the drop down box on the "Dashboard View" box.

User Alerts

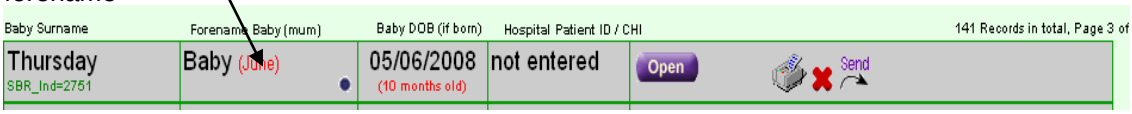
This will warn users to the following:

- Identify any booked but not yet delivered records that are more than 4 weeks past the recorded Estimated Date of Delivery.
- CHIs to be allocated – SBR records which do not have a baby CHI entered on them
- Invalid CHIs – SBR records which have an invalid baby CHI entered e.g. only 4 digits

SBR Update Log

Clicking on the SBR update log will take you to the SBR website. Details of version updates as well as User Manuals and Quick Guides can be accessed here.

Baby Death Indicator
Identifies a baby stillborn or baby death on the dashboard as a dark blue dot next to the Baby forename



Section 4: Finding Your Patient Record

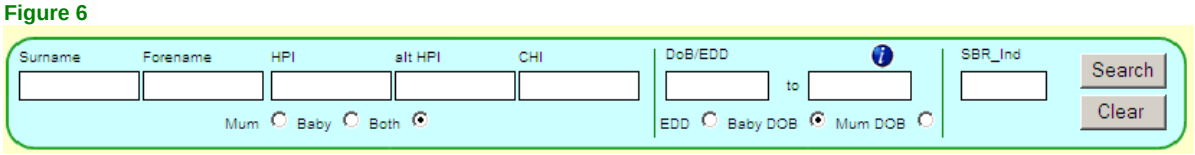
The record you are looking for may already exist on the SBR either having been manually keyed by another user, imported from an existing hospital system or if the baby has been transferred to your hospital in utero. It is therefore always advisable to ensure the record does not already exist on the SBR before adding a new one. If the baby was born or has been treated at another hospital the record may still be with this site. If this is the case you should contact the SBR contact for that site in the first instance. Alternatively contact the SBR team via the ATOS helpdesk - See section 16 Contacting Us.

Finding a Record

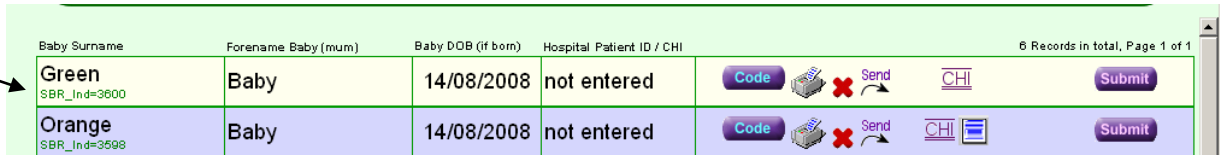
The search facility can be found on the top of the dashboard.

- Search for mother/baby or both using partial surname/forename, HPI, alternative HPI, Community Health Index (CHI) number, Expected Date of Delivery (EDD), Baby DOB, Mum DOD or SBR Indicator*.
- Enter the data you are searching on i.e. surname, DOB, CHI
- Click on the 'Search' button
- Results will also include any alternative/previous surnames
- Remember to select mum, baby or both (it is recommended that you select both)
- There are two boxes in the section for searching on EDD, Baby DOB or Mum DOB. If you want to search just on a singular date you can enter this in either box. If you want to search on a range of dates put the start date in the left box and the end date in the right hand side box.
- Remember that if you want to search for certain records i.e. those with EDD dates you need to change to a dashboard view that shows them, i.e. 'All' or Booked but not yet delivered 'BBNYD'.

Figure 6



- The SBR Indicator is a unique system identifier for each SBR record. It can be found below the surname on the dashboard.



Section 5: Adding a New Record

Before adding a new record it is advisable to search the database to ensure a record does not already exist - see above.

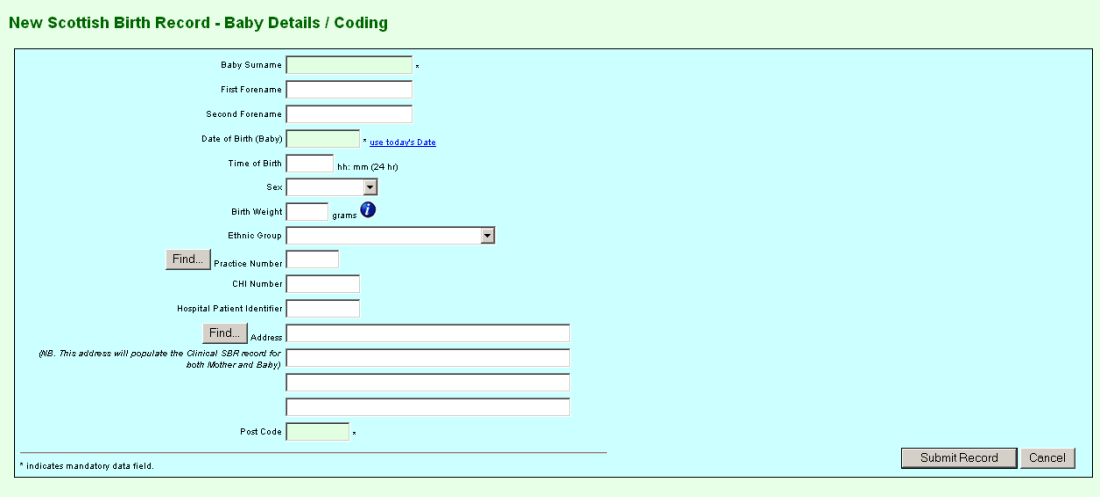
To add a new record for the Baby;

- Click on 

from the main dashboard
- Complete all the mandatory fields (these are marked with *)
- Click on 

Please note that for multiple pregnancies each baby will require a record. If a new record has been added for the Mum via the clinical section the number of records required should be already on the system.

Figure 7



Hints:

- Click on use today's Date to default the baby's date of birth to today's date.
- There is an Information Point next to the Birth Weight field. This field should be entered in grams and stored as 4 digits. Preceding zeros should be entered if the weight is less than 1000g.
- If the connection is slow, please do not keep clicking on the "Submit Record" button as this may create multiple records.

Section 6: Opening a Record

Once you have entered records into the system an abbreviated record will appear on the dashboard including details of Baby Surname, SBR Indicator, Baby Forename, Baby DOB and Baby HPI where appropriate.
Simply clicking on the 'Code' button next to each record will take you into the main body of that record. If there are a lot of records on your current dashboard you will need to use the surname/HPI search facility to find the record you want.

Section 7: Multiple births

To record multiple births a separate record must be completed for each baby.

If a new record has been added for the Mum via the clinical section the number of records required should be already on the system.

Section 8: Saving a Record

Before you move screens within the SBR or exit the record click on Update to save the information you have entered. If you try to change screens or exit the record, without updating first a message box will appear notifying you the data you entered has not been saved. Click **OK** to save or **Cancel** to close the record without saving.

Section 9: Deleting a Record

There are a number of reasons why you may want to delete a record from the SBR. If you need a record deleted you should contact your local SBR administrator to do this for you. A list of administrators will appear if you click on the red cross. You should also contact the SBR Project Team if you identify that there is a duplicate record for either the mother or the baby, or if you

accidentally delete a record and you wish it to be retrieved. Note that the deleted record will remain on the main database with a note of who has deleted the record and why.
To delete a record:

- Click on  beside the appropriate record
- Select the reason for the record to be deleted from the following options:
    - **Error** *(duplicate record entered by mistake)*
    - **Miscarriage** *(loss of pregnancy prior to 24 weeks gestation)*
    - **Intra-uterine death** *(any fetal death after 24 weeks gestation but before onset of labour)*
    - **Moved outwith the area** *(either no forwarding address for transfer of care or moved out with Scotland prior to delivery)*
    - **Termination** *(therapeutic abortion)*
- Click on 

Section 10: Entering Patient Information

Access to Patient Records

Once you have created/found your patient click on the 

button on the main dashboard next to the appropriate record to access it. The following tabs will be displayed:

- Baby
- Episode
- Birth
- Codes
- VLBW (only when the baby's details have been entered meet the very low birth weight study criteria)

To access the tabs, click on the appropriate header. These can be accessed in any order.

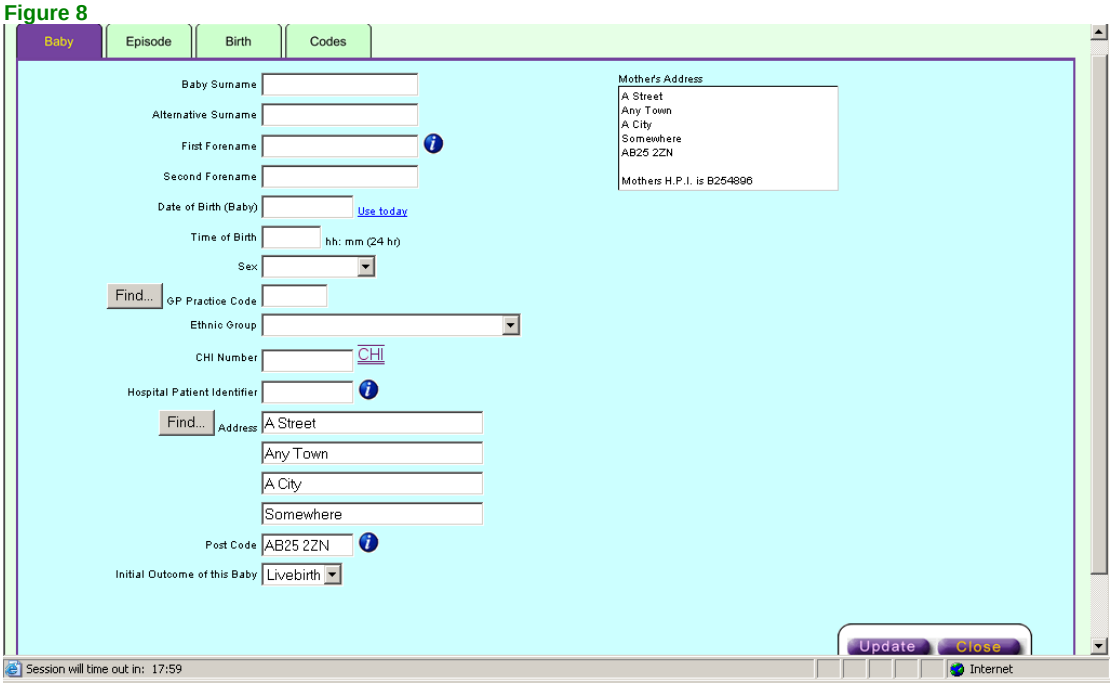
Some of the data items may already be recorded either as they were entered manually when adding a new record or the data was imported from an existing hospital system. If you require clarification on definitions and standards for the SBR data items please contact the SBR Team - see section 16 Contacting Us.

a) Baby Screen

This screen enables you to edit any of the patient or demographic fields associated with a baby including his/her name and GP practice. Please note that the Mother's address and HPI on the right-hand side of this screen cannot be edited here.

Between the hours of midnight and 6am the 'Use today's date' link will be hidden, forcing you to manually enter the date. This has been introduced to reduce the number of incorrect dates of birth entered on the system for babies born during the night.

Figure 8



When a baby is transferred to you from another hospital please overwrite the Hospital Patient Identifier with your own.

Recording Stillbirths

All births should be recorded on the SBR. To record a stillbirth simply change the Initial Outcome of the Baby on the baby screen to stillbirth. This field automatically defaults to livebirth unless you change it.

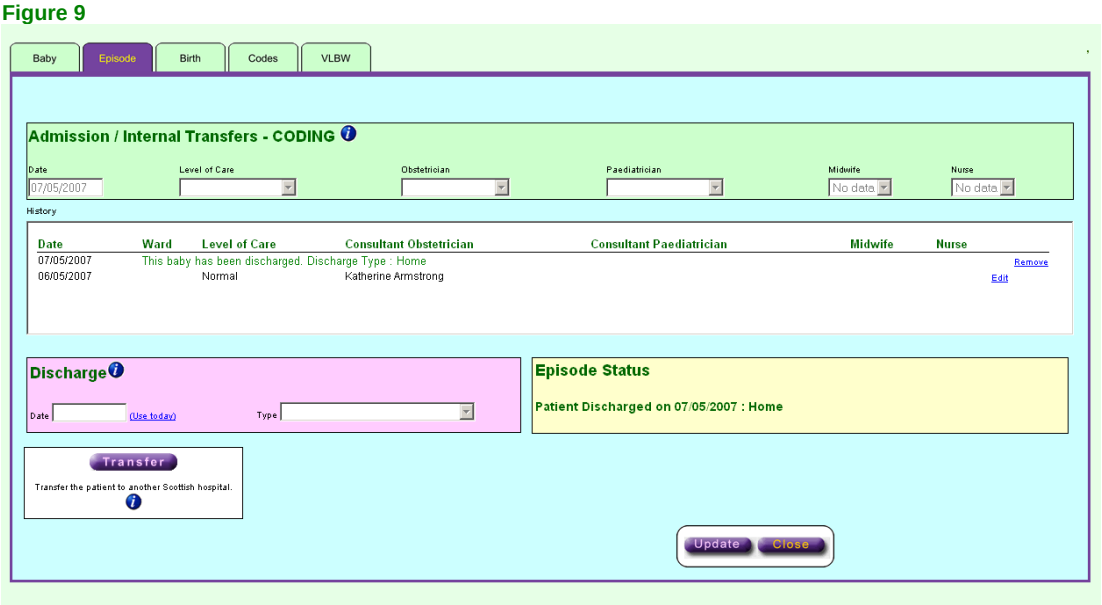
b) Episode Screen

Data recorded here is for **baby activity only**.

Here are some definitions that may be useful to you:

Admission = when a baby is admitted or re-admitted to any ward within a hospital that provides any neonatal care – this includes 'normal' care.
Transfer = when a baby is transferred to another Scottish hospital for neonatal care. **Note** before a record is transferred it should be completed with all available information – a transfer should be the last thing you do with the record as currently once you transfer it you no longer have access to it.
Discharge = when a baby is discharged from inpatient care to the community, transferred to specialist non-neonatal care, e.g. cardiology, or transferred to a hospital out with Scotland.

Figure 9



To add an episode:

- Complete the boxes within the "Admission/Internal Transfers for this baby" box, at the top of the screen (the green area).
- If you want to use today's date click on the "Use Today" link above the date field. (NB the admission date defaults to the baby's DOB)
- You must have either an obstetrician \ paediatrician or midwife selected to record an episode
- Click on Update to save the episode

The last episode added would always be populated in the "Admission/Internal Transfers for this baby" box, to add a new episode, overtype the existing data and click on Update.

To add a discharge:

- Complete the "Discharge from hospital for this baby" box at the bottom of the screen (the pink area).
- If you want to use today's date click on the "Use Today" link below the date field.
- Select the Type of discharge.
- Click on Update to save the discharge.

The discharge will be added to the top of the episode history box.

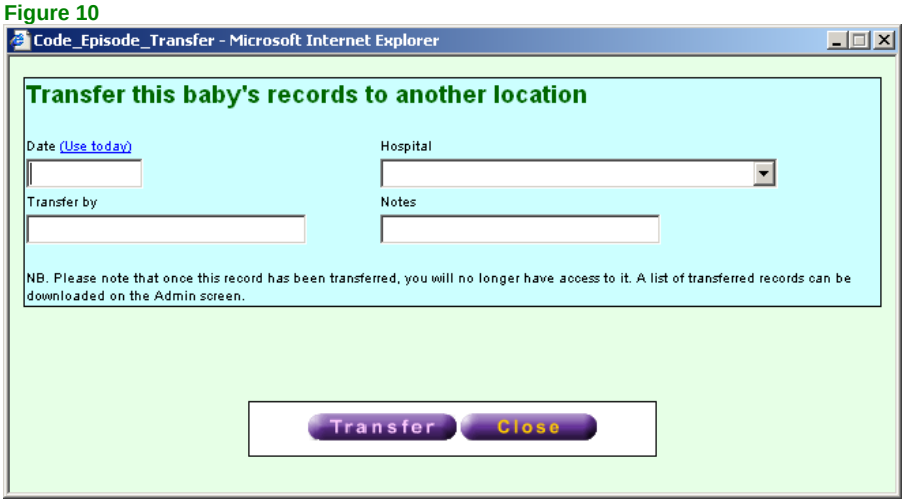
Note: You always read the episode history box from the bottom upwards as new episodes of care are added to the top of the list.

If you want to remove a line in the Episode History box then simply click on the remove button next to each line and **start from the top down** – so in this case it would be the discharge that would be removed first.

See page 13 regarding for recording of homebirths.

Transferring a Patient

Figure 10



This screen is used when the baby is being transferred from your hospital to another Scottish hospital for continued care. If they have not been admitted to the other hospital i.e. only visiting another hospital, use the send facility instead.

To transfer:

- Click on Transfer (on the Episode screen)
- Complete the date (click on the "Use Today" link to use today's date)
- Select the hospital the patient is being transferred to. To select the hospital quicker type in first letter of hospital and the box will be populated with the full name. If there are several hospitals beginning with the same letter, continue to hit the relevant key (the first letter of the name) until the Hospital you are looking for appears
- Enter who carried out the transfer and add any appropriate notes
- To complete the transfer click on Transfer
- To cancel the transfer click on Close

By transferring the baby's record on the SBR you are simply changing the access rights to this particular record. The new location will have full read and edit access. Note that if the baby is transferred to England this will be treated as a discharge (Discharge Type = 'Facility / Hospital Outwith Scotland') as the Scottish Birth Record system is not available outside Scotland. The discharge date in this instance is the date the baby leaves Scottish hospital care.

Tips for Transferring:

- Do not use the transfer screen when a baby is being moved between wards within the same hospital, this should be recorded as a new episode.
- At present once a record has been transferred you cannot access it unless the record is transferred or sent back to you.
- Ensure that you complete the record with as much information as possible **BEFORE** you transfer the record as once you have transferred/sent it you will no longer have access to it.
- If you have transferred a record and have forgotten to add something please contact the designated SBR user at the receiving site. If you have transferred to the wrong hospital please contact the SBR Project Team who can un-do the transfer for you.
- If you want to transfer a baby that has been born, to another hospital you must ensure that the baby has been admitted on the '**Episode**' screen first.
- If a baby has been transferred to you, you must admit the baby on the '**Episode**' screen before it can be discharged.
- A list of records that have been transferred from your hospital can be viewed on the Admin page.
- It is hoped in the future to retain read only access to transferred baby records. You would not be able to edit any transferred records.

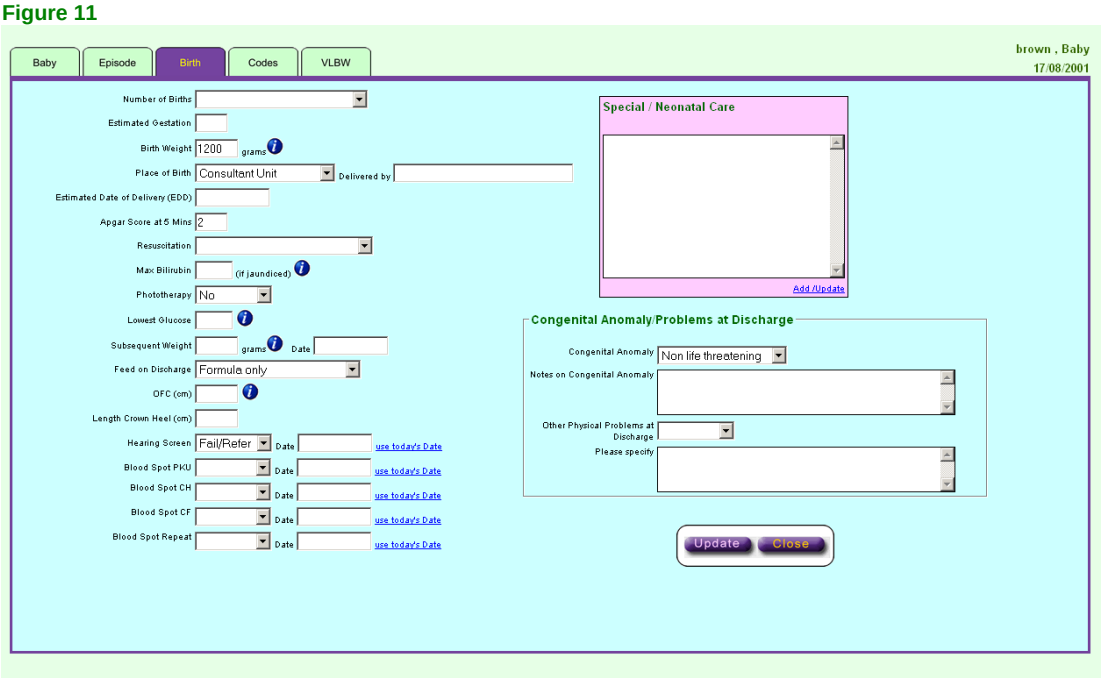
Readmissions

When a baby has been readmitted to hospital after transfer or discharge this must be entered on the episode screen. To do this, follow the instructions above detailing how to add an episode.

c) Birth Screen

Details on the birth can be entered and edited on the 'Birth' screen. Information here includes estimated gestation, feeding on discharge and congenital anomalies. Information Points are provided beside various data fields to give information and guidance.

Figure 11



Any notes on congenital anomalies made by clinical staff will appear under the congenital anomaly/problems at discharge section.

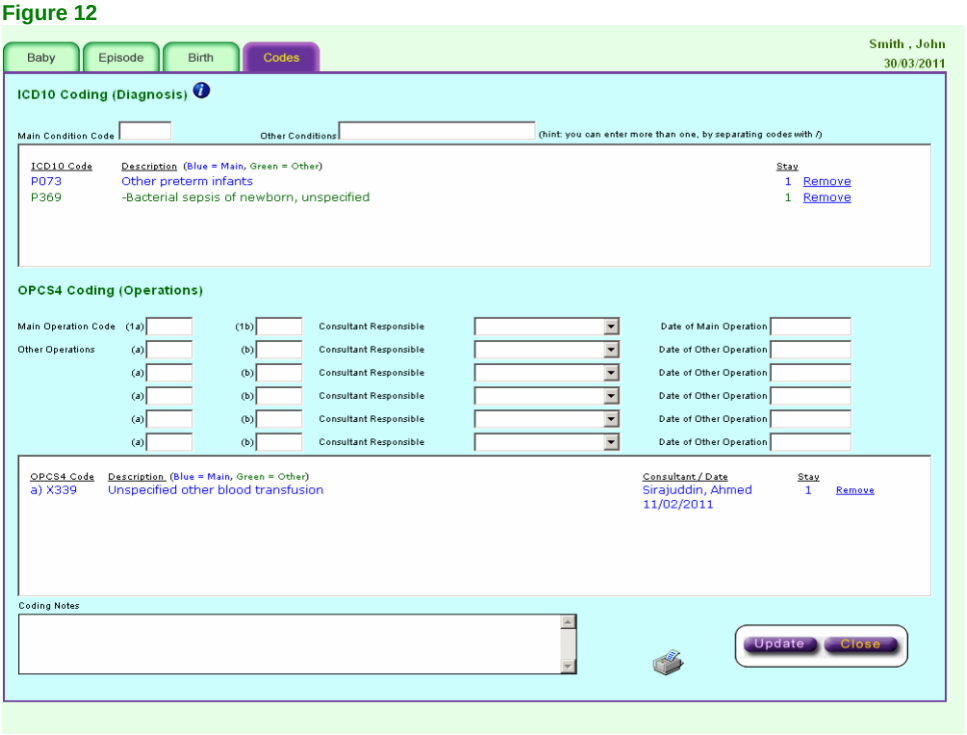
The Special/Neonatal care box shows any diagnosis or procedures entered by the clinical staff. This information may be useful to you when you are adding ICD10 and OPCS4 codes to the record.

Recording Homebirths

Homebirths can also be recorded on the SBR. Simply change the 'place of birth' field on the birth screen to either 'Home Birth Plan N/K', 'Home Birth Planned', or 'Home Birth Unplanned'. The baby can be admitted as a homebirth on the episode screen by selecting Level of Care 'Homecare' and then select Discharge Type as 'Homebirth'. The record will remain in the current view of records unless the baby is discharged from care.

d) Codes Screen

Figure 12



This screen enables you to enter ICD10 and OPCS4 codes for each stay* the baby has in hospital. It is important to check you are coding the correct stay number – to check for the dates of each stay please refer to the Episode screen. The screen above shows this baby has 2 stays.

*A stay is classed from admission to discharge from hospital. Therefore each time a baby is readmitted to hospital after a discharge/transfer it has a different stay number. A stay can be comprised of a number of transfers within the one hospital or between different hospitals

To enter ICD10 codes:

1. Select the stay you want to code by clicking on the drop drown box at the top right of the screen and selecting the appropriate number
2. Enter the main condition code and any other conditions, if required, into the appropriate fields.
3. To enter multiple ICD10 codes, put a / between codes for the 'Other Conditions.' There is no limit to the number of codes you may enter.
4. Click on the update button at the bottom of the screen and the textual description then appears in the history box.

To enter the OPCS4 codes:

1. Select the stay you want to code by clicking on the drop drown box at the top right of the screen and selecting the appropriate number
2. Enter the operation code into the appropriate fields.
3. Add the consultant responsible
4. Add the date of main operation,
5. Click on the update button.

You can enter 2 or more OPCS4 codes that are the same as long as the dates of the operations/procedures are different.

The functionality to remove OPCS4 and ICD10 codes as well as a free text box at the bottom of the screen for comments is also provided.

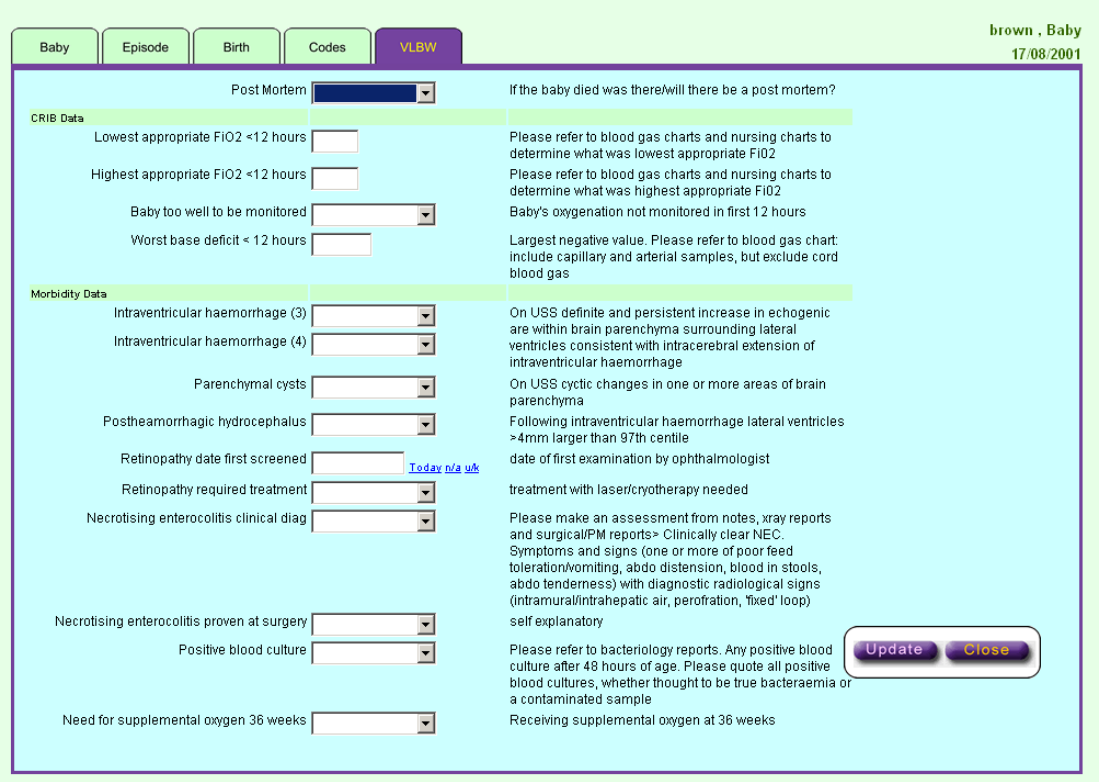
Please note that only codes relating to the baby should be entered on this screen and not any codes relating to the Mother.

A Coding Output document is available from the Printroom if required

e) VLBW Screen

The Very Low Birth Weight (VLBW) screen is where information on CRIB and Morbidity data are recorded. This screen only appears if the baby meets the VLBW criteria - the baby is either, less than 1500 grams or that they are less than 32 weeks gestation. Completion of this screen is not mandatory for the Information Services return and only needs to be completed where the VLBW study is being conducted.

Figure 13

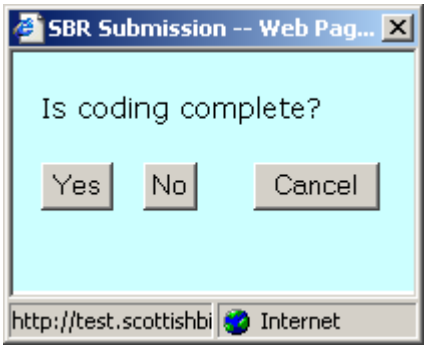


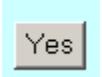
Section 11: Submitting and Retracting a Record

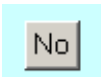
Once you have finished coding the record you can submit it to the SBR database and it will be removed from your current view on opening the SBR. Records can be submitted when they are partially coded or fully coded. If you submit partially coded records, they can be retracted at a later date, fully coded then submitted again.

To submit a record:

1. Click on 



2. Click on 

for fully coded records and 

for partially coded records.

Once you have submitted a record and realise you have more coding to do:

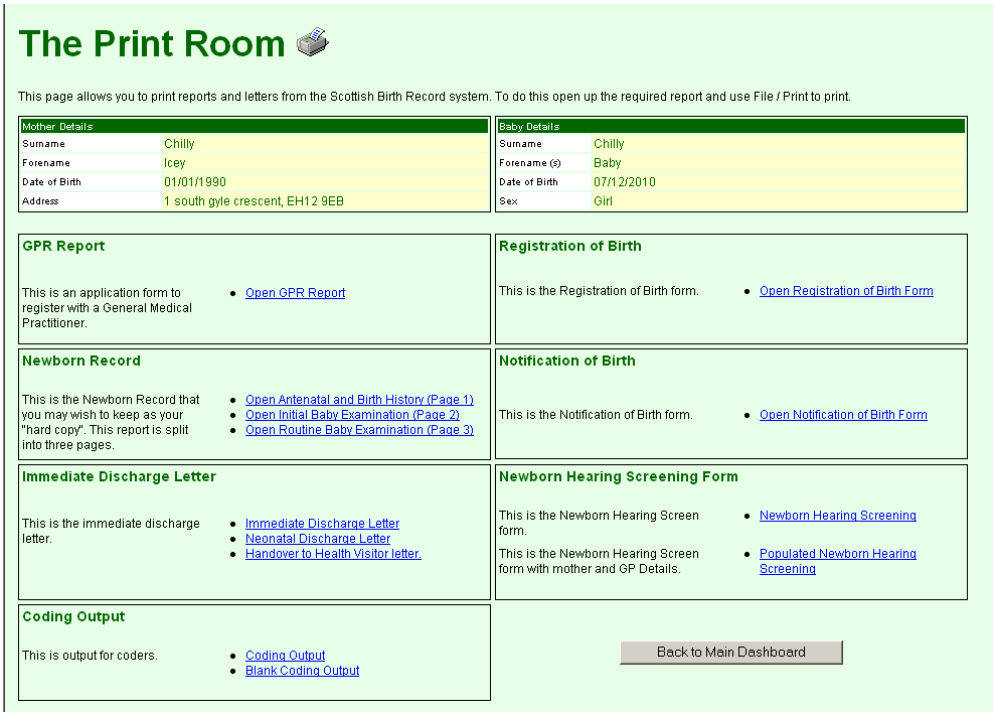
1. Search for your patient. – See section 4: Finding Your Patient Record
2. Click on “Retract” under the “Fully or Part Coded” icon Retract
3. Open the record as detailed above.

Section 12: Print Room

To open the Print Room:

1. Click on  beside the appropriate record on the main dashboard
2. Click on the document you wish to open (it will appear in blue and underlined)
3. Once the document is open, go to File
4. Select Page set-up and ensure the header and footer boxes are blank
5. Click on OK

Figure 14



The print room allows you to print reports and letters relating to a particular record from the SBR system.

To print the document:

1. Go to File
2. Select Print

The following reports can be generated from The Print Room:

- GPR Report – An application form to register with a GP
- New Born Record – A printable version of the data relevant to a new born split into antenatal birth history, physical baby examination and medical baby examination .
- Immediate Discharge Letter – A pre-populated discharge letter for mother and baby. Note – if a mother has had no previous pregnancies then it will display on this letter as being para 0+0.
- Neonatal Discharge Letter - A pre-populated discharge letter for babies who were admitted for further neonatal care.

- Handover to Heath Visitor Letter - A pre-populated letter containing information for the Health Visitor.
- Coding Output – A pre-populated report containing a summary of all the coded data together with the OPCS4 and ICD10 codes for the baby.
- Blank Coding Output - A blank report for recording the coded data items including OPCS4 and ICD10 codes for the baby where the notes are housed elsewhere.
- Registration of Birth – A pre-populated Registration of Birth form.
- Notification of Birth – A pre-populated Notification of Birth form.
- EC58 – A pre-populated EC58 form, which is under development.
- Newborn Hearing Screening Form – A blank screening form with the patient information pre-populated**.**
- Pre-populated Newborn Hearing Screening form – this is prepopulated with GP and Mother details.

Section 13: System and Password Administration

To access the Admin screen, click on 

from the main dashboard.

This screen allows you access to the following functions: -

- User administration
-
- SBR User Manuals and Quick Guides
- Automated imports
- Record movement
- Tools

User Administration
Your view of this section will vary depending on the type of user you are.

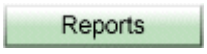
- Coding User – This is where you can change your password.

SBR User Manuals and Quick Guides
Click the link to open a new browser window and view the up-to-date SBR User Documentation. This lists all the current manuals and guides which can be downloaded.

Automated Imports
If you are automatically sending files to the SBR database then you can access your own Automated Import Log. This enables you to view a log of the files you have sent in, how many records were in each file and if it was successfully imported into the SBR.

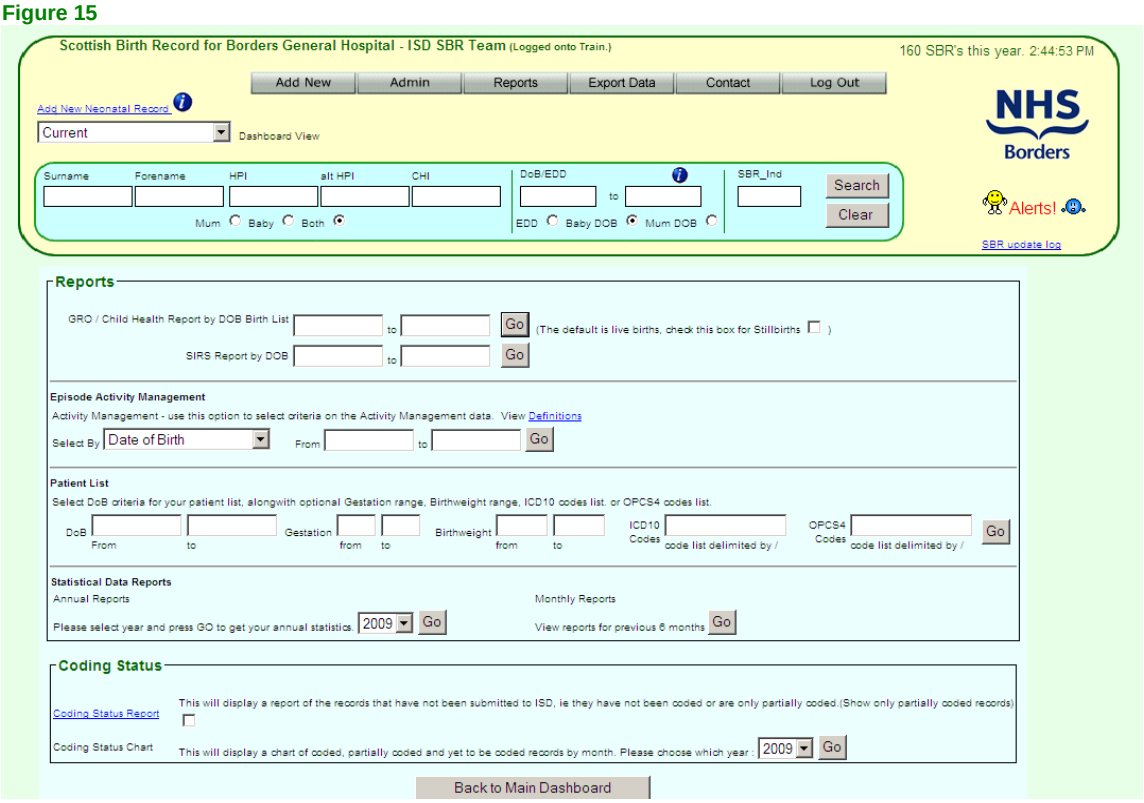
Record Movement
This allows you to view a list of records, which have been in utero transfers, transferred or sent from your hospital via the SBR.

Section 14: Reports

Clicking on 

from the main dashboard allows access to reports and graphical analyses of the data entered into the system.

Figure 15



The following reports are available:

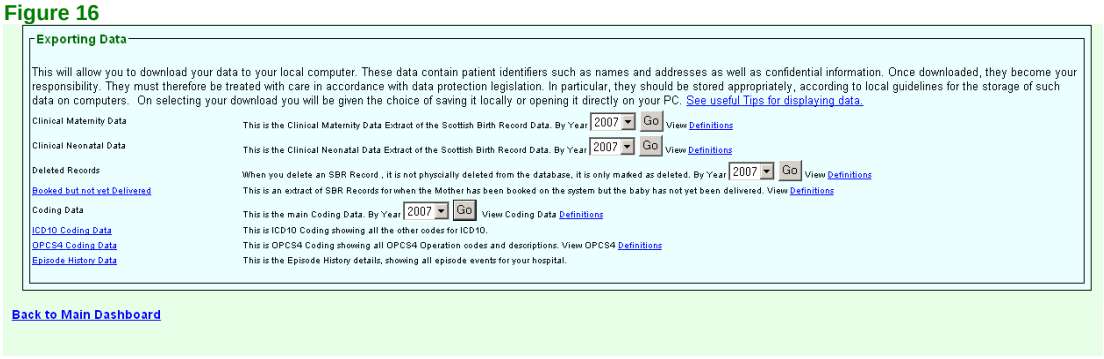
- GRO/Child Health Report – This report gives a list of all the babies born within the hospital (can include still births if requested) for a specified period of time.
- SIRS Report – A more detailed list of all the babies born within the hospital for a specified time period. (N.B The initial outcome field must be set for baby to appear in this report).
- Episode Activity Management – This is a report required primarily for finance. The user can choose to limit this report by specifying a date range for the following dates:
    - Date of birth
    - Date of admission
    - Internal transfer date
    - Date of discharge
    - External transfer date
- Patient List – reports on patients by either dates of birth, gestation, birth weight, ICD or OPCS codes
- Annual Report – shows full birth details including; gestation, birthweight, feed on discharge, discharge type, multiples, top 10 diagnosis – 4 digits, top 10 diagnosis – 3 digits, ITU days, ITU ALOS, HDU days, HDU ALOS, SCBU days, SCBU ALOS, Vent days, VENT ALOS, HFO days, HFO ALOS, CPAP days, CPAP ALOS and percentage of total by selected year. (ALOS = average length of stay).
- Monthly Report - cover the previous six months and they display the following: Birth Number, Outcome, Place of Birth, Birthweight, Gestation, Feed on Discharge, Parity, Onset of Labour, General Anaesthetic, Epidural Anaesthetic, Local Anaesthetic, Spinal Anaesthetic, Blood Loss, Placenta Delivery, Tears, Episiotomy, Type of Delivery.
- Birth Weight – Provides an analysis of the birth weights for the current hospital with a national comparison.

- Baby Sex – Provides an analysis of the baby genders for the current hospital with a national comparison
- Coding Status Report – This report will show all the records that have not been submitted to ISD i.e. they have not been coded or only partly coded.
- Coding Status Chart – This will display a chart of coded, partially coded and yet to be coded records by month for a specified year.

Section 15: Export Data

Clicking on Export Data from the main dashboard allows information to be taken from the SBR and printed out or analysed in a local system.

Figure 16



Data entered into the SBR can be downloaded, then printed out or analysed locally. These SBR data extracts and reports contain up to the minute information that has been entered at your hospital. The download is in a pure text format enabling you to import it into any programme for analyses. Please note that you require Office 2000 to be able to view the data from this page.
To download the information:

- Click on Export Data from the main dashboard
- Select the year beside the appropriate dataset you wish to extract i.e. Clinical Neonatal Data
- Click on 'Go'
- Select if you wish to "Open" the data from its current location or want to "Save" it to a secure location.

Note: once downloaded the data becomes your responsibility. This data must be treated with care in accordance with data protection legislation. Please remember that the data will remain on the hard disk of your computer after you close the SBR and that data may still be retrievable even after deletion.

The following downloads are available:

- Clinical Maternity Data – All maternity data extracts based on a particular year for the current hospital.
- Clinical Neonatal Data – All neonatal data extracts based on a particular year for the current hospital.
- Deleted Records – A list of all records that have been marked as deleted for the current hospital.
- Booked but not yet delivered – all records with have no baby date of birth recorded.
- Coding Data – All coding data based on a particular year for the current hospital.
- ICD10 Coding Data – A dump of all the ICD10 codes assigned to each SBR for the current hospital.
- OPCS4 Coding Data – A dump of all the OPCS4 codes assigned to each SBR for the current hospital.
- Episode History Data – A list of all episode events for the current hospital.

Alongside each data extract is a Data Definitions document detailing the content of each extract. In addition there is a section on 'Useful Tips for displaying data' that may be helpful to you. In order to view these definition documents you will need to have Adobe Acrobat Reader on your computer.

If you experience any problems opening up these Reports please try the following - Open up Windows Explorer, go to Tools/ Folder Options/ File Types – scroll down to CSV and click on the 'Change' button and change it so that the association is with Excel. You should now be able to open up the SBR file and either save it as an Excel or CSV file. If not please contact the SBR Team.

Statistics from the SBR

As the data entered into the SBR is up to date this will give you more accurate, timely analysis of different types of data.

Each Scottish Birth Record has its own unique number which is generated by the SBR system. This is called the SBR Indicator. You should use this field to link data with and to eliminate any duplicate episodes.

If there is any specific analyses you require or you just need help getting the data out of the excel spreadsheets then contact the SBR Project Team via the Atos Helpdesk.

Section 16: Contact

The SBR helpdesk is maintained by Atos Origin and is available 24/7. You can contact them in a number of ways:

- Use the 

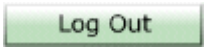
link on the dashboard and complete the form.
- Email: itservicedesk.nhss-ns@atos.net
- Telephone: 0845 957 2700

Atos Origin is the first point of contact if you require assistance. They can help immediately with the following:

- Find an SBR User
- Reset passwords
- Provide details of who you should contact to get a record transferred
- Add new postcodes to the system
- Unlock the baby CHI

Any other problems or queries will be passed to the SBR team who will get in touch with you during normal office hours.
It is important that you do not use any confidential data in emails. The SBR Identifier should be used to identify records that are being queried; see Section 4 Finding Your Patient Record.

Section 17: Logging Out

Always click on 

from the main dashboard to exit the system.

To close down the system click on Exit or press **Alt + F4**

If you have any problems closing the system down please contact us.

If the system freezes you can use the **'Alt'** and **'F4'** buttons together. Remember that if you have not pressed the 'Update' button on your current screen then any data items you have entered will be lost and not saved.

The SBR system will automatically log you out of the system if it has not been used for 20 minutes. However any unsaved data will be lost.

Section 18: CHI Interface

The Scottish Birth Record system has the facility to obtain a Community Health Index (CHI) number for babies shortly after birth. If your hospital is participating in this functionality a CHI button will be visible on the main dashboard.

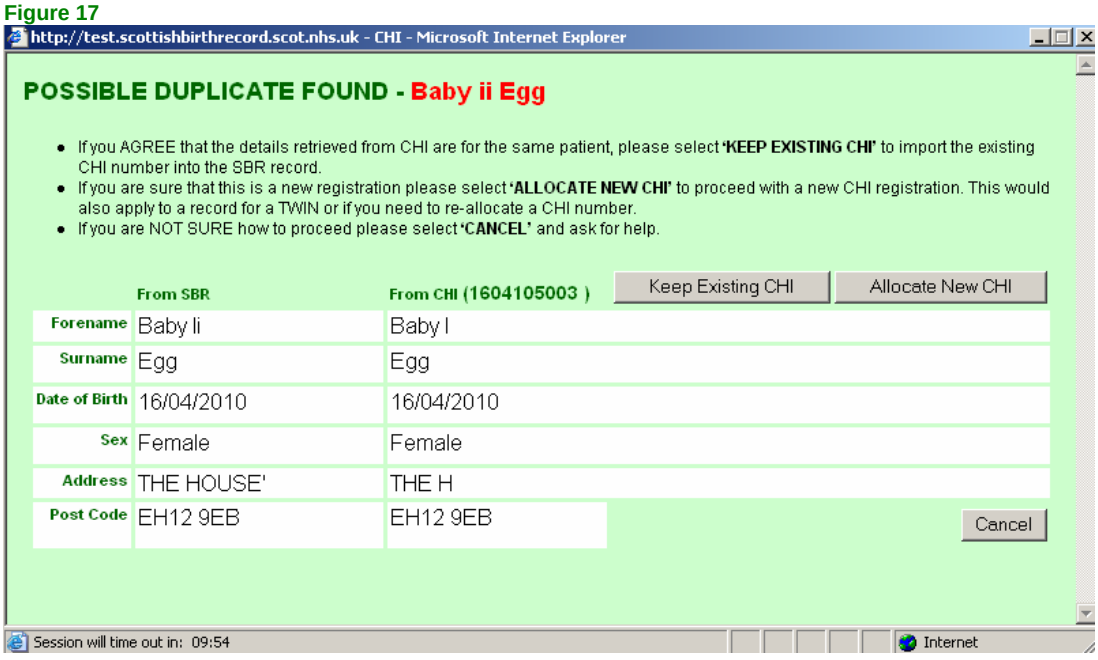
To obtain a CHI:

- Click on the CHI button on the main dashboard next to the record you want to get a CHI number for. **Note** that if a CHI number for this baby has already been obtained via the SBR, or has been entered manually into the relevant field on the Baby screen, then this CHI button will not be available to you
- You will be presented with a screen that will show you the details you are sending to CHI to register this baby in order to get a CHI number back. Please ensure that these details are correct – if not please cancel, go back to the record and amend where necessary. When allocating a CHI number, the background colour of the pop up box will correspond to the gender of the baby: Blue =Boy, Pink =Girl.
- Once you have obtained a CHI number via the SBR it will automatically populate the CHI field on the Baby screen and you will not be able to edit this field

In order to obtain a CHI number the record you are sending must have a baby surname, baby forename (default "Baby" is valid), valid postcode (it must include a space), sex, baby date of birth, and first line of address.

It is important that if you are registering multiple births, where the baby has no forename (and the default "Baby" is being used), please use Baby I, Baby II, Baby III etc. as the validation will not accept numeric characters.

Figure 17



The above screen means that the data you are sending to the CHI system appears to match an existing record please check carefully before you proceed:

'Keep Existing CHI' button

- Click on this button if the details are for the same patient and you are **not** trying to re-allocate the CHI number. You will then retrieve the CHI number previously allocated to that baby.

'Allocate New CHI' button

- If, after checking the details, you are confident that the details that already exist on CHI belong to a different baby then you can go ahead and get a CHI number by clicking on this button. This option would be used for a multiple birth.
- If you are reallocating a CHI number to a baby and this message is displayed, click on the 'Allocate New CHI' button to get a new CHI number. This option would be used where the wrong details had been entered (e.g. wrong sex) the first time that the CHI was allocated.

'Cancel' button

- If however you are unsure, you think this baby may already be registered on CHI or you want to go back into the record to check it then please click on the 'Cancel' button. **It is very important that the same baby is not allocated two CHI numbers unless the CHI number needs to be re-allocated because it was based on the wrong details (and therefore invalid).**

If any of the required data for obtaining a CHI is incorrect or missing you will be shown an error message indicating what you are required to amend prior to being able to obtain a CHI number.

Your local administrators and also staff at the Atos helpdesk are able to unlock the CHI if an incorrect CHI has been allocated. If the CHI is unlocked and another CHI allocated please ensure that the Child Health department are made aware of the CHI change so they can stop using the old one.

If you have any problems or need any assistance to allocate a CHI number, please do not hesitate to contact the SBR Team via the Atos helpdesk.

Section 19: Audit Trail

There is an activity log incorporated into the system at data item and username level. Whenever a record is accessed or any data item is added / amended, the date, time and username are recorded on the audit log.

Section 20: Fault Finding

Problem	Possible Cause	Action
Unable to submit a new record	The mandatory fields have not been completed	Complete all necessary fields – refer to page 13
The system has closed down and returned to the initial log-in screen	The system has automatically closed as it has not been used for 20 minutes – any unsaved data will be lost	Log back in to the system if you want to continue inputting data
The system continually crashes	There appears to be a problem with the hardware (the PC itself)	Inform your IT department
The data you have just added is no longer there	The update button has not been clicked and so the data has not been saved to the database	The lost data will have to be added again ensuring that the 'update' button is used.
You are unable to view the entire screen	The screen resolution on your pc is incorrect for this application	Please refer to the system pre-requisites in Appendix A.
A message appears saying that this 'record is locked for editing'	Another member of staff in your Hospital has this record open	Once they have closed this record you will be able to access it yourself
You are unable to access the excel file in the 'Reports' section		Please report the fault to the Project Team at Information Services.
A dialogue box appears asking you if you need help completing the form	Your pc has the incorrect AutoComplete setting	Please refer to the pre-requisites in Appendix A.
The background colour on the forms in the Print Room is being printed	The Print settings for Internet Explorer are set to print background	Follow the steps in Appendix A.
'Page cannot be found' error displays	The NHSNet is currently down or there is a fault with the SBR.	Report the problem to your IT helpdesk.
You have forgotten your password		Please contact your local Password Administrator.

If the SBR seems to be going slow here is a tip that you can try to improve performance.

Empty your browser's temp files.
After constant use of the browser, this is the program you use to actually access the SBR system; your pc becomes blocked up with temporary files, stored in a temporary files folder. It is wise to empty (i.e. delete) these files from time to time.

To delete the Temporary Files:

1. Click on 

2. Go to TOOLS
3. Go to INTERNET OPTIONS
4. Select the GENERAL tab
5. Under the section "Temporary Internet Files", click on the button DELETE FILES
6. Check the box "Delete all offline content"
7. Click OK
8. It may take a minute or two, depending on the amount of TEMP files
9. Once it is completed, click OK

Appendix A – Technical Pre-Requisites

Internet Explorer Pre-Requisites for the Scottish Birth Record Web Based System

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Version

For the Scottish Birth Record to work, version 5.5 or later (128 bit) of Internet Explorer must be installed.

Printing

To print the reports, standard letters and forms your computer will have to be connected to a colour printer. You need to ensure that you have “print Background Colours” enabled – This can be found by:

- Right clicking on 

- Go to Properties
- Go to Advanced
- Scroll down to PRINT OPTIONS
- Tick the box “Print Background Colours”

Internet Explorer Toolbars

The Scottish Birth Record runs in Kiosk mode, which means the application opens up Internet Explorer without any toolbars visible. However, to print reports, we utilise the Internet Explorer window, which automatically has toolbars present.

AutoComplete to be turned off

One feature of Autocomplete is that a dialogue box will appear asking if you require assistance completing the form. To switch this mode off:

1. Open **Internet explorer**
2. Go to the **Tools** menu
3. Click **Internet Options**
4. Click on the **Content** tab
5. Under **Personal Information**, click Autocomplete
6. Deselect the 'Forms' check box and the ‘usernames & password on forms’ box
7. Click ok.

Screen resolution to be set at 1024 x 768

To change your screen resolution

1. Click on 

at the bottom of your screen
2. Select **Settings**
3. Click on **Control Panel**
4. Double-click on **Display**
5. Go to the **Settings** tab
6. Under **Screen** area, click on and drag the slider to 1024 x 768
7. Click **Apply**

Notes

- A higher resolution reduces the size of items on your desktop
- A lower resolution increases the size of your desktop
- Your monitor and display adapter determine whether you can change your settings or not. (Any doubts, please contact your IT department)

Appendix B – Setting Up Icons on Your Desktop

Setting up a Training SBR logo on your desktop

- Firstly ensure that your PC is linked to the NHSNet
- Right click on the desktop
- Select **New**
- Select **Shortcut**
- 'Create shortcut' dialogue box appears – browse to where you have your Internet Explorer (usually on your local disk C / D – Programme Files or Plus or Internet Explorer) – look for the Iexplore.exe 
- Double click or OK
- At end of address put *space*-k*space*http://test.scottishbirthrecord.scot.nhs.uk
- Click on **Next**
- Type in 'Training - Scottish Birth Record'
- Click on **Finish**

Setting up a live SBR logo on a desktop which is linked to the NHSNet.

- Firstly ensure that your PC is linked to the NHSNet
- Right click on the desktop
- Select **New**
- Select **Shortcut**
- 'Create shortcut' dialogue box appears – browse to where you have your Internet explorer (usually on their local disk C / D – Programme Files or Plus or Internet Explorer) – look for the Iexplore.exe 
- At end of address put s*pace*-k*space*https://www.scottishbirthrecord.scot.nhs.uk (note this has to be EXACT or it will not work)
- Click on **Next**
- Type in 'Live Scottish Birth Record'
- Click on **Finish**

Appendix C – Data Entry Guidance/Tips

General

- For security reasons, if there has been no activity with the SBR for 20 minutes the system will log you out losing any data that has been keyed and not updated

- When you enter any information you **must** click on the Update button to save the data. Don't worry if you forget and change screen. A warning message will appear notifying you that data you have entered has not been saved. Click 'OK' to save or 'Cancel' to close the screen without saving

- Information Points appear throughout the system (hover your mouse over them to view)

- **DO NOT** use **BACKSPACE** on the keyboard if you are not clicked within a field, data may be lost as this moves you back a screen

- Where possible, data items shaded in blue should be completed. These are required for the National reporting

- It is important to fill out all fields using correct grammar and spelling as the information recorded can be used within the discharge letters and other documents.

- When creating a new record, those fields, which are accompanied by an asterisk, are mandatory and must be completed before the new record can be added to the SBR. If a mandatory field is missing a warning box will appear providing details of the missing data item(s) which is needed to be completed before the record can be submitted.

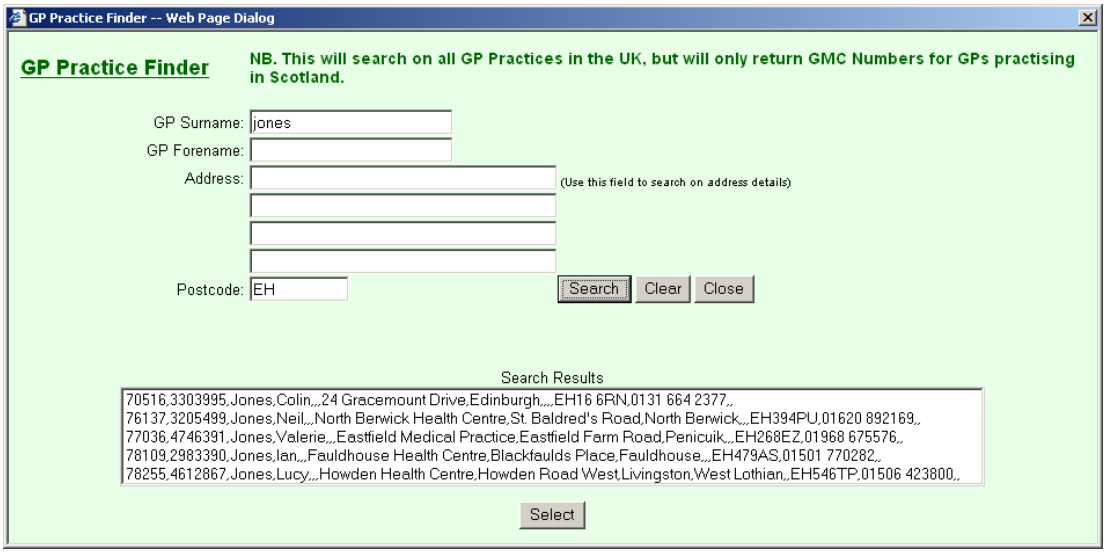
- To find a GP and/or GP Practice please use the find button located to the left of the GP Practice Code field - see GP and Practice Finder below for further details

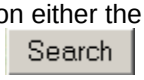
- It is advisable to use the 'find' button when entering addresses as this automatically populates the fields in a standard format. When entering a postcode you must include a space – e.g. FK104QB should be recorded as FK10 4QB – see Postcode and Address Finder below for more details

- If the connection is slow, please do not continually click on the 'Add Record' button when creating a new record, as this will create multiple records

GP Practice Finder

If you know the GP Practice Code and the GP's GMC number you can type these into the relevant data fields. The built in search allows you to find any GP in Scotland and any GP Practice throughout the UK. The more specific your search, the quicker it will run.



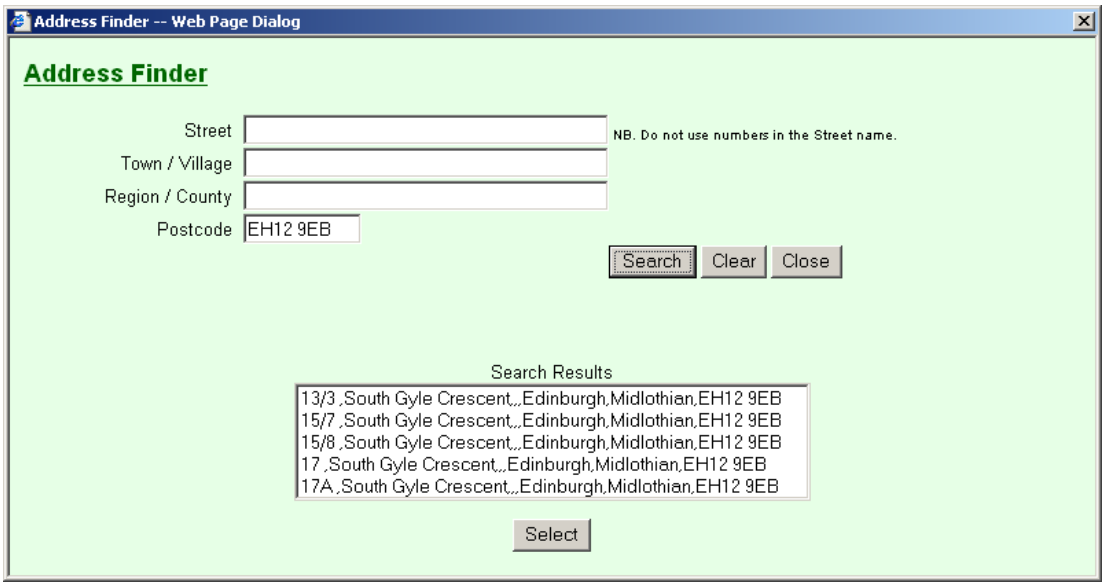
- Click on  to the left of the GP Practice Code field
- Search on either the GP's surname and/or the Practice address
- Click on 
- Highlight (click on) the relevant entry from the list presented of possible GPs and Practices
- Click select
- The GP Practice Code and GP's GMC number are now automatically completed

Hints & Tips for Searching: -

- For surnames beginning with O', just search using O and include some other GP or Practice detail such as forename or partial practice address
- For patients in the Armed Forces who are not registered with a GP in the UK please use GP practice Code 99976
- When searching on the practice address enter details in the first line only – see below
- If you do not find the GP/practice you are looking for, you can widen the search by removing the address, or the GP forename. Be careful if you are looking for a common name such as Dr Smith, it is advisable to put in the first initial to avoid a large set of results being returned.

Postcode & Address Finder

It is recommended that you use the built in search facility to enter the address and postcode.



- Click on  to the left of the address field
- Search on either the postcode or part of the address
- Click on 
- Highlight (click on) the relevant address from the list presented
- Click select
- The address and postcode are now automatically completed

Hints & Tips for Searching: -

- The more specific your search is the quicker it will run. For example, if you are searching for a common street name such as 'High Street' you should also include the town / village
- Do not enter a house name or number in the address search
- When searching on a postcode you **must** include a space in the postcode e.g. EH3 9AW instead of EH39AW

If an invalid postcode is manually entered a warning will appear on screen. Where possible try to find the correct postcode.

However, if you know the address and postcode you can type them in to the relevant fields.

Appendix D - Glossary

Discharge = when a baby is discharged from inpatient care to the community, transferred to specialist non-neonatal care, e.g. cardiology, or transferred to a hospital outwith Scotland.
Transfer = when a baby is transferred to another Scottish hospital for neonatal care. **Note** before a record is transferred it should be completed with all available information – a transfer should be the last thing you do with the record as currently once you transfer it you no longer have access to it. It is important to remember that the transfer facility should only be used if the mother / baby has been admitted to you first. If not then you must use the **send** facility.
Admission = when a baby is admitted or re-admitted to any ward within a hospital that provides any neonatal care – this includes 'normal' care.

Categories of care definitions (based on BAPM 2001)

Intensive Care (ICU1)

- Needing 1:1 nursing care by 405/equivalent
- Intubated
- 24 hours post extubation
- NCPAP + <5 days old for any part of the day
- NCPAP + <1000g for any part of the day
- NCPAP + <1000g 24 hours after stopping NCPAP
- <29 weeks + <48 hours of age
- Pre-operative and 24 hours post operative
- Requiring complex clinical procedures (Exchange, peritoneal dialysis) or treatment with Inotropes, pulmonary vasodilator or prostaglandin
- 24 hours after stopping treatment with inotropes, pulmonary vasodilator or prostaglandin
- On day of death
- Transported by a team including medical/ANNP and nursing staff

High Dependency Care (previously ICU2)

- NCPAP for any part of the day and not fulfilling criteria for intensive care
- <1000g and not fulfilling criteria for intensive care
- Receiving TPN
- Convulsions
- Oxygen + <1500g
- Neonatal Abstinence Syndrome
- UAC / UVC / IA / chest drain / tracheotomy / partial exchange transfusion
- Severe apnoeas
- Needing 2:1 nursing care
- Transported by a trained nurse alone

Special Care
In the SBR this relates to babies who are receiving any special care, regardless of which ward they are in.

Normal Care
In the SBR this relates to babies who are receiving normal care usually on the post natal ward with Mum.

Appendix E - Blank Coding Output Form

Baby Identification

Surname		GP Practice Code		Address	
Forename		Ethnic Group			
2nd Forename		CHI Number			
D o B		Hospital Patient Id		Postcode	
Sex					

Birth Details

No. of Births		Phototherapy		Hearing Screen	
Estimated Gestation		Max Bilirubin		Blood Spot PKU	
Birth Weight		OFC		Blood Spot CH	
Place of Birth		Length Crown Heel		Blood Spot CF	
EDD		Lowest Glucose		Blood Spot Repeat	
Apgar Score at 5 mins		Subsequent Weight		Congenital Anomaly	
Resuscitation		Subsequent Weight Date		Notes on Congenital Anomaly	
Feed on Discharge					
Other Physical Problems /Comments					

Episode Details

Date	Level of Care	Obstetrician	Paediatrician	Midwife	Nurse

Codes

ICD10

Code	Description	Stay No.	Notes

OPCS4

Code	Description	Consultant / Date	Stay No.